Division of Substance Abuse and Mental Health

Quality Assurance Unit
1901 N. DuPont Highway
New Castle, DE 19720
302.255.9414

APPLICATION FOR LICENSURE

(Use a separate application for each program requesting licensure.)

DATE OF APPLICATION: _____

Check one: ☐ INITIAL APPLICATION ☐ RENEWAL APPLICATION

I. ORGANIZATION INFORMATION

Name of Organization or Parent Company

Street Address

City, State, Zip

Administrator Telephone Number

Fax Number Email Address

TYPE OF PROGRAM FOR WHICH APPLICATION IS BEING MADE.

Check all that apply.

☐Non-Profit ☐For Profit

☐Public ☐Other (Specify)

☐Private

II. LICENSED PROGRAM INFORMATION

☐ CHECK HERE IF LICENSED PROGRAM INFORMATION IS THE SAME AS ORGANIZATION INFORMATION. MOVE ON TO SECTION III IF CHECKED.

Program Name As It Will Appear On the License

Program Address

City, State, Zip

Contact Person's Name and Title Telephone Number

Fax Number Email Address

III. TYPE OF PROGRAM LICENSURE FOR WHICH APPLICATION IS BEING MADE.

Check all that apply.

☐Residential Detoxification ☐Non-Residential Detoxification

☐Residential Setting ☐Transitional Residential Setting

☐Outpatient Setting ☐Opioid Treatment Setting

IV. AFFILIATION WITH OTHER REGULATORY OR ACCREDITATION BODIES

List all licensing, certification and/or accreditation bodies your organization is credentialed by (including those in other states.) Use a separate attachment if necessary.

Is your organization affiliated with any other licensing, certification and/or accreditation body?

☐No ☐Yes: If yes, indicate which type:

☐LICENSURE _____
Licensing Body Expiration Date

☐CERTIFICATION _____
Certification Body Expiration Date

☐ACCREDITATION _____
Accreditation Body Expiration Date

Has the organization ever had a license, certification or accreditation denied, suspended, and/or revoked for any program it operates?

☐No ☐Yes: If yes, indicate the program, date, and reason(s) for denial, suspension, and/or revocation:

☐The program is applying for Deemed Status under:

☐CARF ☐JCAHO ☐Other (Specify)

Complete Attachment C for Deemed Status

V. GEORGRAPHIC AREA(S) SERVED BY THE PROGRAM

(PLEASE IDENTIFY THE GEOGRAPHIC AREA BY STATE, COUNTY, CITY, MUNICIPALITY ETC…AS APPROPRIATE)

_____ _____
State(s) County(ies)

_____ _____
City(ies) Other

FOR INITIAL APPLICANTS: Explain the process you used (e.g. Needs Assessment) to substantiate a need for this type of program, at this time, in this particular geographic area. Attach any documentation that substantiates your explanation**. Re-licensure request move onto section VI.**

VI. HOURS OF OPERATION

SUNDAY _____

MONDAY _____

TUESDAY _____

WEDNESDAY _____

THURSDAY _____

FRIDAY _____

SATURDAY _____

VII. FUNDING SOURCES (Please note that licensure does NOT constitute a contract or entitle a program to funding from the Division of Substance Abuse and Mental Health.)

Dollar Amount (in thousands)	Source Description

VII FUNDING SOURCES CONTINUED…

VIII POPULATION

PLEASE PROVIDE CLIENT DEMOGRAPHIC INFORMATION

Children and Youth (17 and under) ☐

Adults (18 and over) ☐

Male ☐ Female ☐

List the average number of clients involved (actual/projected) in the program per month by primary diagnosis.

	Actual	Projected
Primary Alcohol or Drug		
Poly Substance Abuse		
Co-occurring (AOD/MH)		

1. Indicate the average length of stay for clients in the program (actual or projected.) Give answers in days if less than 1 month, otherwise give answer in months.

Actual	Projected
_____	_____

2. Indicate the actual/projected staff to client ratio:_____

    a. Complete Attachment A ***Personnel***

3. Indicate the actual number of members of the organizations Governing Body.

    a. Complete Attachment B ***Governing Body.***

4. If you have or are projecting a waiting list please indicate the number of individuals and the average waiting period preceding admission:

    1. Number of clients on waiting list:

        Actual _____ Projected _____

    2. Average waiting period preceding admission:

        Actual _____ Projected _____

I hereby confirm that the program for which I am applying for licensure conforms to the Delaware Division of Substance Abuse and Mental Health Substance Abuse Facility Licensing Standards; Del 16 §6000.

_____ _____
President of Governing Body/Advisory Council Program Director

_____ _____
Date Date

Attachment A: Personnel ***Page 1***

PERSONNEL

List administrative and clinical staff that will provide services to consumers enrolled in the program for which you are seeking licensure.

Name	Position or Office Held	FTE	PT staff	Degree and/or Credential (	Years of experience AOD Treatment Field

Attachment A: Personnel ***Page 2***

PERSONNEL (Continued)

Name	Position or Office Held	FTE	PTE	Degree and/or Credential	Years of experience in the AOD Treatment Field

Attachment B: Governing Body ***Page 1***

GOVERNING BODY

List all members of the governing authority (i.e. owner, stockholders, board of directors, advisory board) who have legal and ethical responsibility for the program. Provide all requested information. NOTE: If a member of the Governing Body has a relationship with any person employed by the program, an explanation of the relationship must be provided. (Please photo copy additional pages as needed.)

Name of Governing Member	**Position or Office Held**	**Address**

Attachment B: Governing Body ***Page 2***

GOVERNING BODY (CONTINUED)

Name of Governing Member	Position or Office Held	Address

GOVERNING BODY (CONTINUED)

1. Please list all Governing Body members who are related to staff members of the program and explain the relationship.

2. Please explain how the Governing Body is representative of the community it serves.

Attachment C: Deemed Status

Division of Substance Abuse and Mental Health

Quality Assurance Unit

Deemed Status Application

1901 N Dupont Highway
New Castle, DE 19720
302.255.9414

1. PROGRAM INFORMATION

Name of Organization or Parent Company

Street Address

City, State, Zip

Administrator Telephone Number

Fax Number Email Address

2. ☐The program is applying for Deemed Status under:

3. ☐CARF ☐JCAHO

4. Date of your last accreditation survey: _____

5. **Approximate date of your next accreditation survey:** _____

Month **Year**

6. **Accreditation Status (e.g. Full Accreditation, Three Year Accreditation etc…)** _____

- ✓ **If more than one program is accredited under this certificate, please provide the programs names, addresses, names of administrators, phone numbers and email addresses for each on a separate attachment.**

7. **If your program is the first program requesting Deemed Status under you organization's accreditation, please submit the following documents with your Deemed Status Application:**

   a. **A copy of your most current accreditation certificate**

   b. **A copy of your most recent accreditation survey report**

   c. **A copy of your response for corrective action based on your most recent accreditation survey report**

8. **Have these documents been submitted by another program within your organization prior to this application? Y / N If "yes" please provide information on the name of the program and date of the initial submission.**

---

9. **If more than one program is accredited under the same certificate, are all documents being submitted valid for each program? Y / N. If "no" please list other documents for your specific program with copies of each. Include these under a separate attachment.**

Please submit all documents at least 90 days prior to the expiration of your current license to:

Angie Walker, M. Ed
Unit Director; Quality Assurance Unit
1901 N Dupont Highway
Springer Building
New Castle, DE 19720
PH: 302.255.9414 FX: 302.255.4449 Email: Angie.Walker@state.de.us

Attachment D: New Opioid Programs

Division of Substance Abuse and Mental Health

Quality Assurance Unit
1901 N Dupont Highway
New Castle, DE 19720
302.255.9414

APPLICATION FOR NEW OPIOID TREATMENT PROGRAMS

1. **Please attach a list of all Opioid Treatment programs within your organization including: The name of the preferred contact at each program, address, phone number, fax number and email address. Please provide this information under separate attachment.**

2. **Please provide the name and documentation of all credentials (e.g. licenses) for all medical staff that will be working with Opioid patients at the program for which you are seeking licensure:**

    a. **Medical Staff**

        i. _____
        Medical Director License Expiration Date

b. Other Prescribing, Professional Medical Staff:

Name	License/ Expiration Date

c. Nursing Staff:

Name	License/Expiration Date

3. **Medication Dispensing days and Times**

Day	Times
Sunday	_____
Monday	_____
Tuesday	_____
Wednesday	_____
Thursday	_____
Friday	_____
Saturday	_____
Sunday	_____

4. **Please attach copies of the organization's protocols and procedures for Take Home and Detoxification.**

5. **Please attach copies of the organization's protocols for assuring adequate procedures to identify theft or diversion of Opioid antagonist medication.**

6. **Please attach the substantiated need for your program as required in Section V of the *Application For Licensure "For Initial Applicants."***

7. **Please explain how you will collect fees from OTP consumers and the process by which you will provide continuity of care for consumers who are unable to pay for services. Include the projected number of individuals you will refer to DSAMH funded programs within the first year of providing services and documentation of how your projections were estimated.**

8. **Referral to Community Programs**

    a. **Please attach letters of agreement from community programs that you intend to refer consumers to. Include referral sources for Mental Health treatment, DUI treatment, DSAMH funded OTP programs and any other referral source you anticipate developing a relationship with.**

9. **Safety and Security**

    a. **Please explain the program's plans for assuring adequate on and off site security measures to ensure the safety of patients, staff and business and residential neighbors.**

Please include ATTACHMENT D with your initial application for licensure.